

**ROBERT T.  
HARRISON  
DDS PC**

Family Dentistry  
For Everyone With  
Care & Concern

(970) 223-5393

SUITE 101  
383 W. DRAKE RD  
FORT COLLINS, CO 80526-2884  
SATURDAY APPTS.



## Administrative Policies

As purchasers of high quality dental services, we ask you to be financially responsible to our business, just as we are fiscally responsible to our creditors.

**Regarding Payment:** I understand that I am financially responsible for all dentistry performed on my family in Dr. Harrison's office. Payment is expected at the time of service. For your convenience, we gladly accept cash, check, MasterCard, Visa and Discover.

Payment Plans are available through Care Credit with approved credit.

**Regarding Insurance:** I understand that as a courtesy this office will file my insurance and take assignment for that portion which my insurance company should cover. You will be asked to pay your deductible and your portion of the charges the day the service is rendered.

Dental Insurance is **NOT** meant to be a PAY-ALL, it is only meant to be an aid. Your insurance company has set maximum fee schedules for various dental services. These schedules are internal to your insurance company. In addition, the fee schedule is based on the type of coverage your employer has purchased. **Please be advised that you are responsible for the total charges or any difference remaining following payment by your insurance company.** Our office will ESTIMATE as closely as possible your coverage. If you feel that your insurance has not made adequate payment on your services, please contact them to discuss the matter.

Your insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within thirty days. We guarantee accurate filing based on the information provided to us. We expect all insurance payments within thirty to forty-five days. We closely monitor and follow up on all insurance claims. We will hold your insurance portion of your balance for sixty days. On day sixty-one, if your insurance company has not reimbursed our office, you become responsible for the balance. Balances not paid within this time will be assessed a finance fee of 18% per annum or 1 \_ % per month. Balances not paid within ninety days will be subject to collection.

**Regarding Appointments:** Our office reserves time for each patient in our practice. An appointment written in our schedule is a bond of trust that we will be here to serve you and you will be present for that appointment. Therefore, our office policy in this regard is extremely firm and inflexible. You must be present for all scheduled appointments. We do not allow constant cancellations or short-notice changes.

I agree to pay all costs of collections, court costs and attorney fees should I not pay my account in full as agreed.

\_\_\_\_\_  
PATIENT

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DATE